THE IMPACT OF GOVERNMENT REGULATION*

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LET me begin this morning with a warning that the brush I use is quite a bit smaller and the pictures that it paints less global than those produced by Doctors Lashoff and McClure. Both concepts are serious, but mutually exclusive in regard to our future.

Having grown up in a community across the river from New York City, I am aware that there is nothing west of the Palisades, except a large swamp which is New Jersey and a lot of scattered Indian settlements west of the Allegheny Mountains. With this perception in mind, a few words about Cooper Medical Center seem appropriate. Cooper, located in Camden, N.J., is a new 500-bed unit offering many sophisticated care services. Cooper is the clinical site of a designated clinical campus of Rutgers Medical School, scheduled to have 48 full-time students in each of two years starting in 1983. It presently has 70 residents, with plans to increase to 125. There are more than 200 medical staff members. It is, briefly stated, a highly technical hospital for all of southern New Jersey. Cooper provides the broadest tertiary care services offered south of New Brunswick, and serves an area that comprises 40% of the state geographically and about 35% of its population. Its staff is, at the moment, engaged in a town-and-gown conflict arising from the advent of full-time teachers and chiefs who are all faculty members of the Rutgers Medical School. Its voluntary staff is located largely within the affluent suburbs of Cherry Hill, Haddonfield, and Moorestown on the eastern bank of the Delaware in what is essentially suburban Philadelphia.

My purpose today is to look at a microcosmic segment of the system described by Doctors Lashoff and McClure.

Government regulation is clearly the dominant shaping force in today's world of medicine and its unsystematic way of practice. From the moment

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the concept of prepayment for health care was introduced more than 60 years ago, government entered the health care and physician-patient relationship. Beginning in the past and building to the almost fever pitch of the moment, outside pressures are affecting the contract that exists between the receivers of health care services, the professionals who provide those services, and the institutional and corporate frames within which care is provided.

It is not my intent to spend time adding to the cacophony of fault finding, anger, kudos, praise, and all of the other points made at the drop of a phrase, which are the usual epilogue to discussions of "how we should deliver health care."

Let us review how the present practices of institution and physician interaction are impacted by regulations and precedent. In our democratic society most regulations are determined by their legal precedents and an increasing amount of our law is determined by case law and experience.

Within the last decade, incredible changes have occurred throughout the nation based on the premise that control of payment controls the cost of delivery of any health care service. Where the system responds to the needs of the people it serves, and when the bodies guiding it see an appropriate balance between costs and provided services, the program is clearly functional. It reduces costs over time, and responds to both patient need and the physician and institutional needs provided for in its payment. The longest functional example of benign, nondisruptive but effective control of such costs is that of Maryland and its reimbursement system.

In other areas, predominantly in the Northeast, state agencies have adopted the "financial cap" route, and the results have been erratic. Restrictions on depreciation to hold down total costs physically destroy many of our largest and newest institutions because of the difficulty of providing maintenance and repair. New Yorkers are probably more aware of this problem than most others in our nation.

The impact of post facto financial controls on hospitals has stressed the physician-hospital-patient interaction and physician practice. The mode of payment now deeply affects physician-patient interaction. What are some of the questions?

Is it really more effective to do all 20 studies on the latest blood chemistry analyzer than to try to program the "on-stream" system for individual studies, even though it is cheaper? What happens when a physician receives a study that he did not request and finds that it changes his concept of the patient's problem? The immediate reaction is that a

good physician will change his information base, and the physician's relationship with the patient is very good. But suppose that the hospital under discussion has a staff or management who wish to limit the report to those studies ordered, even though the remainder have been done. Suppose that one of the unordered studies influences either positively or negatively a major decision that the physician might have made had he known the unreported results. The legal and professional combinations and permutations possible are legion. What began as a money- or time-saving measure now has a direct impact on the physician and his patient. We must look at this practice prospectively and begin to focus on potential legal and professional implications.

The role of other hospital personnel, such as those in nursing, social service, and the myriad of technical occupations, is increasing in quality assurance measurement. We do not yet have a coordinated system to handle the impact on the institution and its personnel. How will we insure that all of these judgements are both accurate and informed when one looks at the multiple relationships involved?

How many of us have sat through a quality assurance committee meeting which has little or no physician attendance but almost the sole involvement of other health care professionals? I find that my physician colleagues lack the ability to respond cogently to the intent of quality assurance.

There is some evidence that New Jersey is more a state of mind than a political subdivision. But whatever, a vignette of regulation, reimbursement, and wonder is appropriate, adding the subscript that, considering today's role of the hospital as a regulated public utility, this could have happened in any other state.

A small hospital in New Jersey was recently surveyed by the division of the department of health responsible for institutional survey and licensure. In short order, the following occurred: The hospital was informed that it must hire emergency room physicians. The hospital tried to hire such physicians, but could neither find nor afford them, and elected to close its emergency room. However, a certificate of need is required to close an emergency room, and such a certificate of need could not be obtained in the geographic area involved. Failing to close its emergency room, the hospital hired emergency room physicians, as directed. The efficiency and cost of the institution's emergency room (small to begin with) was challenged by the regulator. Their salaries were promptly

disallowed by the same regulatory agency. The hospital went to court, which found that the state must compensate the hospital for the required emergency room physicians. All was fine until the state appealed to the Supreme Court, which decided that the department of health could indeed refuse to reimburse the hospital for a service already required in a licensure program. The saga still continues, and with the multiple legal involvements the only significant gain to be seen is in the area of legal fees.

The above comic opera situation might have been avoided by close and continued discussion. There is obvious need to sit down and discuss such problems with physicians acting together as a group with hospitals and regulatory agencies.

The movement to reduce hospital-bed capacity to control costs raises some interesting problems. Where goes the new qualified physician whose staff appointment cannot be denied by law? He is appointed to a hospital whose staff is filled by influential physicians established within the medical hierarchy. The young physician has a problem before he ever begins to carry out the role for which he has been trained. The appearance of such problems increases with the rising specialization and regulation of technology. Competition is healthy. It is, however, a problem which has ramifications which must be identified, discussed in depth, and handled perhaps most effectively in the system that Dr. McClure outlines. In addition, it has an effect on the relationship between hospitals, their boards, their management, and their staff.

We are all familiar with the furor over the certificate of need for computerized tomography scanners (CAT scanners) in each health systems agency region. What of the anomaly—the privately owned scanner which pushes for reimbursement from third party payors and is outside the regulatory system? If left unchecked, it will undermine the whole regulatory process, although our news media encourage such enterprenurial efforts. The profession and the government create a poor public image in our inability to control our technology because of inconsistencies in policy.

In New Jersey a new system of reimbursement has been developed, financed by a federal grant. It is called "diagnoses related grouping." It is a lump sum payment system which pays by diagnosis, regardless of length of stay. Currently, about 26 hospitals in New Jersey are participating. The mechanism has great potential for cost saving. It creates major pressures

on hospitals and physicians to control length of stay and overutilization of resources, but could lead to unwarranted underutilization of appropriate patient management tools. How can one respond to these pressures and avoid raising the level of physician adrenal hormones almost off the scale? It can only be done by involving the medical staff in all phases of adjustment to the new reimbursement system. However, it is inescapable that the impact of the system forces hospitals directly to affect the medical care practitioner in a way that can only be interpreted as indirect governmental control of his practice. Unfortunately, it is the hospital and its management to whom the job falls to attempt to explain such problems. This major communication problem arises because hospitals have clearly been placed in the "hot seat" from which health care control is exercised. To attempt to continue the outmoded philosophy of the hospital as a "physician's workshop" in the face of such major social and financial change is tomfoolery.

Presently, hospitals do not practice cost control, but rather expenditure constraint. Each year the hospitals prepare budgets that are approved by the state. At the end of the year they are reviewed, and arguments arise over payment, although the expenditures have already been made. We must begin to develop a system which is based on true cost control prior to expenditure and, at the same time, maintain our institutional and professional licensure regarding scope and quality of service. To lose that professional role would be to lose both stature and support to the society we serve.

How can we influence such changes? Dr. McClure certainly suggests a simple and attractive model. Far more important, however, is for physicians to understand that they must exercise leadership, vocal restraint, verbal direction, and—to further mix a metaphor—begin to apply a rifle rather than a shotgun to the various ills that face our profession and its incredibly complex and overwhelmingly important support institutions. In some areas this is going well. In the Northeast it is going poorly, at best. We must invest both the time and interest to interact constantly and deliberately without tirade and recriminations else we shall deserve that which is nigh upon us.